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Disseminated cholesterol embolism presenting as neuromyelitis optica

SIR,—Dr Michel Goldman and coauthors (19 September, p 697) claim to be the first to describe neuromyelitis optica in association with cholesterol emboli. However, although they offer both clinical and pathological evidence for disease of the spinal cord, they give no proof that their patient ever suffered from optic neuritis.

They mention an episode of transient visual loss in the left eye six months previously which they say had been "attributed" to optic neuritis. There are no clinical details relating to this one episode on which the diagnosis appears to have been based, and it is not even clear whether the patient had been examined at the time or whether the conclusions had been made in retrospect on history alone. The only ocular findings presented in the paper were that "funduscopic examination yielded normal results" at the time of admission and that visual evoked responses showed increased latency on the left side.

There are several causes of monocular transient visual loss,[1] some of which are compatible with a normal fundal appearance. In this patient, for example, microembolisation of the retinal artery would be a possibility. The only evidence for a past optic neuritis appears to be a delayed visual evoked potential. As this finding is known not to be specific for optic neuritis,[2-5] it would be valuable to know the magnitude of the delay and whether other conditions known to cause such a delay had been excluded. The presence of demyelination of the optic chiasm, which is described in this report, could in itself be responsible for asymmetrical responses.

Although this comes under the heading of short reports, the authors should give more information about their ocular findings before they can convince the reader that they are indeed describing an optic neuritis in association with spinal cord lesions.

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AUTHORS' REPLY—As indicated in our case report, the ophthalmological symptoms appeared six months before the spinal lesion, and the presumptive diagnosis of optic neuritis was made in another hospital. The demyelination of the optic chiasma observed at necropsy confirmed that the optic tract was implicated in the pathological process. The term "neuromyelitis optica" was used to describe the clinical association of optic neuropathy with subacute transverse myelopathy. We did not suggest that one or the other lesion resulted from the inflammatory process of classical "optic neuritis" or "transverse myelitis." On the contrary, the ischaemic origin of the spinal lesion was clearly documented at necropsy and embolisation was probably also the cause of an "anterior ischaemic optic neuritis."[1]

Cholesterol microemboli have been previously reported to mimic autoimmune or inflammatory diseases such as polyarteritis nodosa,[2] polymyositis,[3] or crescentic glomerulonephritis.[4] The aim of our paper was essentially to point out that cholesterol embolisation should also be considered in the differential diagnosis of neuromyelitis optica viewed as a clinical syndrome.

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Emotional distress in house officers

SIR,—Ms Jenny Firth-Cozens found that preregistration house officers in teaching hospitals were subject to more stress and more depression than those in non-teaching hospitals (29 August 1987, p 533). My first postregistration position was at the Royal Hallamshire Hospital, one of the two main teaching hospitals in Sheffield. I concluded that, in addition to those outlined by Ms Firth-Cozens, two factors were responsible for much of the stress.

Firstly, the building is a tower block with two wards on each floor. Frequently these are wards belonging to completely different specialties—for instance, urology and general medicine. This effectively isolates the junior medical staff in one ward and denies them contact with their fellows on different firms. Although this form of isolation is now widely recognised as a major problem in residential tower blocks, it seems to have been ignored in hospital design.

Secondly, because of a lack of accommodation, the Sheffield Health Authority insisted that all postregistration positions should be classed as nonresident. This meant that senior house officers and registrars were not provided with free accommodation, nor was accommodation available within the hospital. In addition, all junior doctors were instructed that patients who had been seen by a given consultant within the past year were to be reviewed by that consultant's team if they required readmission, regardless of whose team was on duty to admit patients. This further isolated the preregistration houseman, who could be called down to the casualty department to assess and admit a patient, whom he might never have seen before and knowing that if he required advice he would have to call in his senior house officer or registrar from home. There was always a postregistration physician resident for after hours duties, but his main responsibilities were to the admitting team, and he was not expected to help with patients previously admitted under another consultant. The problem on the surgical side was even worse, since the duty surgical registrar was not required to be resident. This arrangement was in direct contravention of the agreement between the British Medical Association and the Department of Health and Social Security on conditions of accommodation and service for junior medical staff. Nevertheless, a court case brought by the British Medical Association proved the contract of employment to be legal and as far as I am aware this state of affairs still exists.

What is required is a radical and logical rearrangement of the working practice of the hospital. A concerted effort must also be made to reverse the health authority's position on nonresident senior house officer and registrar positions. It is not enough simply to support a psychological study into stress in preregistration housemen, although this is a solution of which Sir Humphrey Appleby would be proud.

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Sabbaticals and practice agreements

SIR,—Dr Ian Tait discusses briefly the fundamental problem of convincing your partners of the need (sic) for you to take a sabbatical (12 September, p 644).

The success of any arrangement may depend on it being flexible enough for every partner to find the idea appealing. Their personal circumstances may constrain what they can actually do, so damping their enthusiasm. For example, one partner may have young children or be committed heavily to private education, and the idea of extra holiday may be more attractive than three months' absence from the practice.

We started having sabbaticals in 1970 and with four partners have evolved the following system. Each partner in turn is entitled to an extra eight weeks' paid leave every fourth year, which if taken with four weeks' annual leave and one week of study leave means that he or she can escape to pastures new for a total of three months.

To avoid burdening the partners who remain in residence with too much extra work a locum is employed for eight weeks at the expense of the absent partner. The cost to him may be reduced by finding paid work abroad or "once in a lifetime" by applying to the DHSS for study leave.

So, roughly every four years, as ideas and circumstances change we renegotiate the details such as whether one partner can take two weeks as extra holiday every year instead of the eight weeks every fourth year and whether the practice or the individual partner pays for the locum.

This flexible system has allowed study leaves to be taken and interesting jobs done in places as far apart as Kenya and Brunei. It has been most stimulating and the absence of a partner for three months soon settles down into a routine. Sabbaticals are hard work to organise but well worth the effort if a formula can be devised that appeals equally to all partners.

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Is the tube in the trachea?

SIR,—Dr John Kerr's leading article (15 August, p 400) and the subsequent correspondence (19 September, p 723; 10 October, p 926) on endotracheal intubation have concentrated on technology and neglected psychology. The tense situation which develops when intubation is very difficult but essential leads to a great reluctance to remove a tube that just might be in the right place—as indicated by equivocal chest inflation and breath sounds—especially when the patient's